STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 02/22/12. This visit was in conjunction with a PSR to the Investigation of Complaint IN00104470 completed on 02/29/12. This visit was in conjunction with a PSR to Complaint IN00104877 completed on 03/09/12. This visit was in conjunction with the Investigation of Complaints IN00105519 and IN00106360. Survey dates: April 18, 19, 20, 23, and 26, 2012 Facility number: 010739 Provider number: 155764 AIM number: N/A Survey Team: Regina Sanders, RN, TC (April 18, 19, 20, 23, 2012) Kelly Sizemore, RN Marcia Mital, RN Sheila Sizemore, RN Census bed type: SNF: 46	F0000	The submission of this plan of correction does not indicate an admission by Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus . This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities.(for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Residential: 70 Total: 116 Census Payor type: Medicare: 39 Other: 77 Total: 116 Sample: 7 Supplemental Sample: 11 Residential Sample: 3 Residential Supplemental Sample: 2 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 5/04/12 by Suzanne Williams, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F0157	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident B who no longer resides in our facility. 2. An audit of the 24 hour reports and residents	05/16/2012

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			current plan of care were reviewed related to status changes and physician notification. No other residents were affected by this practice. 3. Licensed nurses were re-in serviced on notification of physician with status changes that have a potential for requiring a physician intervention. A nurse practitioner has been employed to monitor residents' medical needs and intervene as indicated. 4.The Director of Clinical Health Services (DHS) /designee will conduct audits of daily orders, Change of Condition documentation, 24 hour report and Circumstance charting 5 times per week for six months. DHS will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved	
	Based on record review and interview, the facility failed to notify the resident's physician related to the resident frequently pulling an ileostomy bag (bowel movement collection bag on the abdomen) off her abdomen, resulting in excoriation and irritation to the resident's abdomen, for 1 of 1 resident reviewed for ileostomy care in a total sample of 7. (Resident #B)			

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	Findings include: Resident #B's closed record was reviewed on 04/19/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, short bowel syndrome and hypotension. The resident was discharged to the hospital on 03/04/12 at 1:18 p.m. A Nurses' Note, dated 03/03/12 at 4 p.m., indicated, "Colostomy (sic) care given x5 (five times) this shift. Res. (resident) cont (continues) to pull off...area around colostomy remains excoriated..." A Nurses' Note, dated 03/04/12 at 11:30 (no a.m. or p.m. documented), indicated, "...excoriation around site remains. Res cont to pull off. changed (triangle) x3..." The Nurses' Notes, dated 03/03/12 and 03/04/12, lacked documentation to indicate the facility notified the resident's physician the resident was continually pulling the ileostomy bag off. Resident #B's Emergency Room physician notes, dated 03/04/12, indicated, "...Ostomy with surrounding erythema (redness), no induration or fluctuance..." Resident #B's Gastroenterology consult			

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	note, dated 03/05/12, indicated, "...she also had excoriation of the ileostomy site due to poor placement of the ileostomy bag the last couple days..." During an interview on 04/19/12 at 2:10 p.m., LPN #3 indicated she had notified the facility's Medical Director only about the excoriation of the area. She indicated she had not documented the physician notification in the resident's record. This deficiency was cited on 2/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State			

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	long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. Based on record review and interview, the facility failed to provide a resident with a notice of transfer or discharge, which informed the resident of the reason for the transfer or discharge, the information about the right to appeal the action, and the name and number of the State Long Term Care Ombudsman, for 1 of 3 residents transferred out of the facility in a sample of 7. (Resident #B) Findings include: Resident #B's closed record was reviewed on 04/19/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, short bowel syndrome and hypotension. The resident was discharged to the hospital on 03/04/12 at 1:18 p.m. The Nurses' Notes, dated 03/04/12 at 11:30 (no a.m. or p.m.) , indicated the	F0203	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident B who no longer resides in our facility. No adverse findings were noted. 2. An audit of residents discharged or transferred from the facility to the hospital during the last seven days were reviewed. No other residents were affected by this practice. 3. Staff will be re-inserviced on to providing a resident with a notice of transfer or discharge, which informs the resident of the reason for the transfer or discharge, the information about the right to appeal the action and the name and number of the State Long Term Care Ombudsman on discharge or transfer from the facility. 4. The Director Healthcare Services (DHS)/designee will conduct audits of residents charts who transfer or discharge to assure	05/16/2012

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	ambulance company had been notified of the transfer. The ambulance transfer record, dated 03/04/12, indicated they transferred the resident at 1:18 p.m. There was a lack of documentation in the resident's record to indicate a notice of transfer/discharge was given to the resident. During an interview on 04/20/12 at 9 a.m., the Regional Vice President, indicated the facility could not find where a Notice of Transfer Form had been given to the resident. 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(D) 3.1-12(a)(9)(E)		the information related to of the reason for the transfer or discharge, the information about the right to appeal the action and the name and number of the State Long Term Care Ombudsman on discharge or transfer from the facility was provided. DHS will conduct audits to ensure appropriate documentation is present for discharge residents 5 times per week for six months. DHS will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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F0226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F0226	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident. No adverse findings were noted. 2. Investigations related to allegation of abuse and suspected crimes were reviewed. No other residents were affected by this practice. Ongoing reports of known, suspected, or alleged abuse have been investigated and reported in accordance with guidelines. 3. The content of the Trilogy Abuse Policy was reviewed for accuracy and was found to be complete. The staff was inserviced on the definition of immediate to be "as soon as possible" and to not exceed 24 hours. Staff will be re-inserviced on the facility's policy for Abuse/Elder Justice Act and the procedures for reporting of any allegations of abuse to ensure protection of the residents.4. The Executive Director will conduct audits of residents' allegations daily to assure that the facility implemented the policy concerning investigation and reported timely any allegation. The Executive Director will report findings to QA&A monthly for six months. 5. QA&A will monitor	05/16/2012

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			monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

A. Based on record review and interviews, the facility failed to implement the facility's policies for Abuse and the Elder Justice Act and train their employees related to the facility's policies and procedures for protection of the residents, reporting allegations of abuse and suspected crimes under the federal Elder Justice Act and the facility abuse policy, for 8 of 17 employees interviewed. This had the potential to affect 46 of 46 residents who reside in the facility. (Employees #1, #3, #4, #5, #6, #7, #8, and #9)

B. Based on record review and interview, the facility failed to develop and implement an abuse policy for timely reporting of allegations of abuse to the Indiana State Department of Health, for 1 of 2 residents reviewed for abuse allegations in a total sample of 7. (Resident #C)

Findings include:

A. 1. During an interview on 4/18/12 at 11:50 a.m., CNA #4 indicated she had an inservice on the facility's abuse policy and

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	the Elder Justice Act about one month ago. CNA #4 indicated she could not find the binder at the nurses' station to tell her about what she should do for the Elder Justice Act. CNA #4 could not explain the procedure for calling the Indiana State Department of Health of a suspected crime. CNA#4 was unsure of what procedure she should take if the nurse did not respond. 2. During an interview on 4/18/12 at 11:45 a.m., LPN #3 indicated if she had a staff member suspected of abuse she would send the staff member to work on another unit until she had investigated the allegation. 3. During an interview on 4/18/12 at 12:00 p.m., CNA #5 indicated she had been inserviced on the Elder Justice Act, but could not remember the inservice. 4. During an interview on 4/18/12 at 12:00 p.m., CNA #6 indicated she had been inserviced on the Elder Justice Act, but could not remember the inservice. 5. During an interview on 4/18/12 at 10:15 a.m., RN #7 indicated if she was reporting suspected abuse, she would call the Director of Nursing. RN #7 indicated she would "call the Administrator if the Director of Nursing wanted her to."			

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	6. During an interview on 4/18/12 at 2:20 p.m., RN #8 (an employee from a sister facility who was helping out at the facility while management staff were at a meeting) indicated she had been inserviced on the Elder Justice Act. RN#8 was unable to indicate who to call or report a suspected crime of abuse to. 7. An interview on 4/18/12 at 11:40 a.m., LPN #9 indicated she did not have the authority to send a suspected staff member of abuse home. LPN #9 indicated she would call the nursing supervisor. RN #9 was unsure of where the Elder Justice Act was posted at in the facility. RN #9 indicated she had been given a pamphlet but was not sure what to do. 8. During an interview on 4/20/12 at 5:15 a.m., LPN #1 indicated she would remove the suspected staff member from the resident's room and ask the resident their side of the story. LPN #1 was unsure of the chain of command of who to go through to report an allegation of abuse. LPN #1 indicated there were no bosses on the midnight shift. During an interview on 4/19/12 at 9:33 a.m., the Clinical Nurse Operations, RN, indicated the nurses have been told they			

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	have the authority to send a suspected staff member home. She indicated the nurses are uncomfortable with that and call the Director of Nursing and let her send the suspected staff member home. A facility policy, dated 11/2010, titled "Abuse and Neglect Procedural Guidelines,"indicated "...has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedure: 1...has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...b. Training: Provide training for new employees through orientation and with ongoing training programs. Training will include, but is not limited to:...4. How to provide protection for residents...6. How to investigate and report incidents of actual or suspected abuse or neglect...Identification...iv. IMMEDIATELY notify the Executive Director...e. Protection:..iv. Suspend suspected employee(s) pending outcome of investigation...Investigation. i. The Executive Director is accountable for investigating and reporting...Reporting...ii. 24 hour initial			

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	reporting to applicable state agencies...." A facility policy, dated 8/2011, titled "Reporting Crimes Pursuant to the Elder Justice Act," indicated "Purpose: The purpose of this policy is to outline how (name of company) will comply with legal requirements that it notify certain individuals of their duty to report crimes to the Secretary of the Department of Health and Human Services and to local law enforcement...Notification of Duty to Report...c. Serious bodily injury - within two hours...No serious bodily injury - within 24 hours. B. During an interview on 4/18/12 at 10:25 a.m., Resident C indicated the staff did not like her and yelled at her. Resident C indicated no one had washed her up, and a staff member had walked out and slammed the door. Review of the investigative reportable incident indicated the facility reported the incident to the Indiana State Department of Health on 4/18/12 at 9:57 p.m. This was 11 hours and 32 minutes after the allegation of abuse was first reported. During an interview on 04/20/12 at 4:20 p.m., the Administrator indicated his understanding regarding reporting was "when you first become aware it is severe			

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	in nature, within two hours." A facility policy, dated 11/2010, titled "Abuse and Neglect Procedural Guidelines," indicated "...has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedure: 1...has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...Investigation. i. The Executive Director is accountable for investigating and reporting...Reporting...ii. 24 hour initial reporting to applicable state agencies...." This deficiency was cited on 2/29/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(a)			

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	155764	A. BUILDING 00 B. WING	04/26/2012

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure residents received medications as ordered by the physician for 2 of 7 residents reviewed for following physician's orders in a total sample of 7. (Residents C and G) Findings include: 1. Resident G's record was reviewed on 4/19/12 at 9:15 a.m. Resident G's diagnoses included, but were not limited to, hypertension, post left shoulder joint replacement, and anxiety. Resident G's admission physician's orders, dated 2/4/12, indicated an order for Carafate (a stomach medication) 1 gram tablet four times a day. A physician's order, dated 2/4/12, indicated "May give Norco (a pain medication) 7.5/500 mg (milligrams) po (orally) Q (every) 4 hours when Norco 7.5/325 is unavailable." The 2010 Nursing Spectrum Drug Book,	F0282	1. Resident's G and C medication records were reviewed and order clarification were obtained. No adverse findings were noted. 2. An audit of residents' medication records were reviewed. No other residents were affected by this practice. 3. Licensed nurses were re-inserviced on administration of medication in accordance with the physician order, Medication Administration Times Procedures, and documentation required related to medication administration. Medication Pass observations and competencies were completed with nurses. 4. The Director of Clinical Health Services/designee will conduct audits of residents' daily physicians orders and MARs five times weekly to assure administration of medication in accordance with Medication Administration Times Procedures, and documentation required related to medication is complete. Follow-up random medication pass observation will be scheduled with nurses. This observation pass will include all shifts three times per week. DHS /designee will report findings to QA&A monthly for six months. 5.	05/16/2012

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	indicated Carafate should be administered one hour before meals and at bedtime. The resident's MAR (medication administration record), dated 2/12, indicated the Carafate was administered at 6 a.m., lunch, dinner, and bedtime. This had been marked through and "rewritten" had been hand written on 2/10/12 after the 6 a.m. dose had been initialed as administered. The resident had received the Carafate on 2/5/12 through 2/9/12 at lunch and supper instead of an hour before the meals. The resident's MAR, dated 2/12, indicated as of 2/10/12, Carafate 1 gram tablet po QID (four times a day) was given at 6 a.m., 11 a.m., 4 p.m., and 9 p.m. (before meals). The resident's controlled drug records, indicated the resident's Norco 7.5/325 milligrams had been received from the pharmacy on 2/5/12, 2/13/12 and 2/22/12. The Norco 7.5/500 milligrams was administered to the resident on 2/6/12 at 12:00 a.m., 2/6/12 at 6 a.m., 2/6/12 at 7 p.m., 2/7/12 at 4 a.m., 2/8/12 at 6 p.m., 2/9/12 at 2:30 a.m., 2/10/12 at 8 a.m., 2/10/12 at 2:15 p.m., 2/11/12 at 10:45 a.m., 2/17/12 at 9:30 p.m., 2/18/12 at 2:30 a.m., 2/20/12 at 8:30 p.m., and 2/21/12 at 7:30 p.m.		QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

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During an interview on 4/19/12 at 2;20 p.m., the Corporate Nurse Consultant indicated the nurses should not have given the Norco 7.5/500 milligrams after the Norco 7.5/325 milligrams was delivered from the pharmacy on 2/5/12. She indicated the Carafate should have been given before meals.

2. During an observation on 04/18/12 at 10:25 a.m., Resident #C was sitting in her room and eating breakfast.

Resident #C's record was reviewed on 04/19/12 at 10:45 a.m. The resident's diagnoses included, but were not limited to, dementia, arthritis, and gastroesophageal reflux disease (GERD).

A physician's order, dated 04/10/12, indicated, Prevacid (stomach medication) 30 mg (milligrams), one tablet before breakfast.

A physician's order, dated 04/11/12, indicated, tramadol (pain medication) 50 mg three times a day before meals.

The MAR, dated 04/12, indicated the Prevacid was scheduled to be given, "before breakfast". The MAR indicated the Prevacid was given April 11, 12, 13, 2012 at 9 a.m. and April 14, 15, and 19,

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	2012 at 10 a.m., and April 16, 17, and 18, 2012 at 8-8:30 a.m. The MAR, dated 04/12, indicated the tramadol was scheduled to be given "before breakfast, before lunch, and before dinner". The MAR indicated the tramadol was given at 10:30 a.m. on 04/18/12 and 10 a.m. on 04/19/12. The MAR then indicated the resident received the tramadol before lunch and before dinner, with no times documented when the medication was given. The meal service schedule, received from the facility, indicated breakfast is from 7 a.m. to 10 a.m., lunch is at 12:15 p.m. and dinner is at 5:15 p.m. During an interview on 04/19/12 at 10:55 a.m., RN #12 indicated Resident #C usually sleeps in until 9 a.m. or 10 a.m. She indicated if the morning medication is given late, she usually tries to give the lunch medication later. She indicated the resident usually eats lunch at 1 p.m. and indicated the tramadol is given close together if given late. During an interview on 04/19/12 at 11 a.m., RN #12 indicated the resident had already been eating breakfast when the tramadol and Prevacid had been given on 04/18/12 and 04/19/12.			

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	An undated policy, titled, "Medication Administration Times Procedural Guidelines", received from the Corporate Nurse Consultant on 04/20/12 at 11:25 a.m., indicated, "...Medications that have been ordered at specific time shall be administered at the time designated by the attending physician..." This deficiency was cited on 02/22/12 and 03/09/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)			

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F0309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F0309	1. Resident's G, H, M, L, and I pain medication records were reviewed and order clarification were obtained. No adverse findings were noted. Due to the passage of time there is no opportunity to correct the circumstances related to resident H emesis and staple removal. No adverse findings were noted. 2. An audit of residents related to current pain status, pain medication orders, change of condition charting, circumstance charting, and physician orders was completed on current residents. No adverse findings were noted. 3.Licensed nurses were re-inserviced on assessing pain, clarification of physician orders, obtaining a physician order, assessment / documentation required with PRN pain mediation administration, required assessment documentation with nursing procedures completed per physician order. Medication Pass observations and competencies were completed with nurses. 4.The Director of Healthcare Services/designee will	05/16/2012

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			conduct audits of the MARs, daily orders, change of conditions documentation, and Circumstance charting 5 times per weekly. Follow-up random medication pass observation will be scheduled with nurses. Observation will include all shifts three times per week. DHS/designee will report findings monthly to QA&A for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved	
	Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and services related to administration of as needed pain medication in a timely manner, assessment of a resident after an emesis, assessment and removal of staples, and assessing residents' pain, for 2 residents in a sample of 7 residents reviewed for receiving the necessary care and services in a total sample of 7 (Residents G and H) and 3 of 7 residents in a supplemental sample of 11. (Residents I, L, and M) Findings include: 1. Resident G's record was reviewed on			

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	4/19/12 at 9:15 a.m. Resident G's diagnoses included, but were not limited to, hypertension, post left shoulder joint replacement, and anxiety. A physician's order, dated 2/4/12, indicated "May give Norco (a pain medication) 7.5/500 mg (milligrams) po (orally) Q (every) 4 hours when Norco 7.5/325 is unavailable." An Admission Minimum Data Set Assessment (MDS), dated 02/11/12, indicated the resident frequently had severe pain (rated at a 6). A care plan, dated 2/22/12, indicated "Pain Acute AEB (as evidenced by) Complaint of pain R/T (related to) Recent surgery...monitor and report to nurse...PRN (as needed) pain medication..." During an interview on 4/18/12 at 2:25 p.m., Resident G indicated she did not get a pain medication one night not too long after she was admitted into the facility, because a CNA did not report to the nurse that she was in pain. She indicated when the nurse came in to check her blood sugar, she told the nurse she was in pain, and the nurse apologized and told her the CNA had not reported to her that the resident was in pain.			

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	During an interview on 4/20/12 at 5:27 a.m., LPN #1 indicated she had an incident once, but could not remember the date, when a CNA had not reported to her that a resident was in pain. She indicated the resident had reported to the CNA at about 3 a.m. and she was not aware the resident had pain until 4 a.m. She indicated the CNA no longer worked at the facility. 2. Resident H's record was reviewed on 4/18/12 at 1 p.m. Resident H's diagnoses included, but were not limited to, fractured left hip, hypertension, and arthritis. A) Resident H's admission nursing assessment, dated 3/30/12, indicated the resident had a surgical incision with 15 staples to her left hip The resident's record lacked documentation of a physician's order to remove the staples from the resident's left hip. A skilled nursing assessment, dated 4/6/12, indicated "4/4/12 3 p.m., Incision has 2 staples to well approximated incision..." There was a lack of documentation of an			

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	assessment for the removal of the resident's staples or of the incision. During an interview 4/19/12 at 11:11 a.m., the Corporate Nurse Consultant indicated the physician had sent an order over to remove the staples, but they were not able to find the order. During an interview on 4/20/12 at 8:22 a.m., the Corporate Nurse Consultant indicated the nurse who had removed the staples had missed 2 staples, so another nurse found the 2 staples and removed them. She indicated the nurse who had removed the staples should have counted to be sure she had removed all the staples. She indicated neither nurse had documented an assessment when the staples were removed. B). Resident H's admission physician's orders, dated 3/30/12, indicated Tylenol 500 mg milligrams) every 4 hours as needed for mild to moderate pain and Tramadol (a stronger pain medication) 50 mg every 6 hours as needed for moderate to severe pain. An Admission MDS Assessment, dated 04/06/12, indicated the resident was cognitively impaired and had frequent complaints of moderate amount of pain.			

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	The resident's MAR (medication administration record), dated 4/12, indicated the resident had received the as needed Tramadol on 4/1/12, 4/2/12, and 4/15/12. There was a lack of documentation on the back of the MAR to indicate an assessment of the resident's pain had been completed. The resident's prn medication tracking form, lacked documentation of any documentation of an assessment of the resident's pain for the above dates. There was a lack of documentation in the Nurses' Notes, dated 04/01/12, 04/02/12, and 04/15/12, to indicate the resident's pain had been assessed. During an interview on 4/18/12 at 1:15 p.m., LPN #3 indicated there should have been a pain assessment completed when the resident received the as needed Tramadol. She indicated it should have been documented on the prn form or back of the MAR. C). A change of condition form for resident H, dated 4/2/12, indicated the resident had 2 episodes of emesis at 1:00 p.m. The form indicated the resident's vital signs were taken and the physician had been called. There was a lack of documentation to indicate an assessment			

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	of the resident's abdomen and bowel sounds had been completed. The back of the form indicated the follow up on 4/2/12 the 3 p.m.-11 p.m. shift, 4/3/12 the 11 p.m.-7 a.m. shift, the 7 a.m.-3 p.m. shift and the 3 p.m., - 11 p.m. shift, 4/4/12 the 11 p.m.-7 a.m. shift, 7 a.m.-3 p.m. shift, and 3 p.m. - 11 p.m. shift, and 4/5/12 the 7 a.m.- 3 p.m. shift all lacked documentation of any assessments of the residents abdomen or bowel sounds. During an interview on 4/19/12 at 11:40 a.m., LPN #3 indicated if a resident had an emesis the resident should be assessed. She indicated the resident's abdomen should be assessed for bowel sounds and be monitoring for any signs of dehydration. During an interview on 4/19/12 at 11:11 a.m., the Corporate Nurse Consultant indicated as a nurse she would assess the resident's abdomen and bowel sounds if a resident had an emesis. 3. During the medication pass observation, on 4/20/12 at 5:28 a.m., LPN #1 administered medication to resident M. Resident M asked LPN #1 for a pain pill. LPN #1 then went back to the medication cart and removed a Norco 5/325 milligram tablet and administered the medication to the resident.			

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Resident M's record was reviewed on 4/20/12 at 5:43 a.m.

Resident M's physician's orders, dated 4/12, indicated the resident had orders for Tylenol 325 milligrams two tablets every four hours as needed for pain and Norco 5/325 milligrams one every four hours as needed for pain.

During an interview on 4/20/12 at 5:43 a.m., LPN #1 indicated she had not assessed the resident's pain. She indicated the resident had orders for Tylenol and Norco for pain. She indicated the CNA had reported to her the resident had complained of leg pain earlier.

4. During an interview with Resident L, on 4/19/12 at 9:30 a.m., she indicated sometimes the nurses are late with her prn (as needed) pain medication or they forget. She indicated, "I usually have to ask one more time. I don't ask for them during the day, mostly in the evening or night shift. The night shift you wait the longest. I waited three hours one night about a month ago." The resident was unable to indicate what night she waited three hours.

Resident L's record was reviewed on

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	4/19/12 at 2:40 p.m. Resident L's diagnoses included, but were not limited to, hypertension, diabetes mellitus, and revision of left knee. An Admission MDS (Minimum Data Set) Assessment, dated 1/27/12, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15 (cognition intact, no impairment), had pain frequently which limited day-to-day activities (over the last 5 days), and rated pain an "8," (over the last 5 days, with zero being no pain and ten as the worst pain you can imagine). The CAA (Care Area Assessment) for pain, dated 01/27/12, indicated, "Res (resident) experiencing pain...Res also utilizes PRN pain medication. Res is s/p (status post) L (left) knee surgery. Res also has a diagnosis of arthritis. Res able to make needs known, and will ask for PRN medication if needed..." The Physician recapitulation orders for 3/2012, indicated an order for Norco (pain medication) 10/325 milligram tablet give 1 tablet by mouth every 4 hours as needed for pain. The MAR, dated 03/12, indicated the resident received the Norco multiple times per day, except on 03/17/12 and			

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	03/22/12. 5. Resident I's record was reviewed on 4/19/12 at 2:22 p.m. Resident I's diagnoses included, but were not limited to, fractured ribs, arthritis, and hypertension. A physician's order, dated 4/2/12, indicated Norco (pain medication) 75/325 mg (milligrams) every four hours for pain as necessary. An Admission MDS Assessment, dated 03/19/12, indicated the resident had no cognitive deficits and had no complaints of pain. The April 2012, MAR indicated Resident I received the pain medication twice on 4/4/12 and one time on 4/6/12 and 4/15/12. The backside of the April 2012, MAR was not marked for any as necessary pain medication being administered. Resident I's "PRN Medication Tracking" dated 3/12 and 4/12, was not marked for the medication, date/time, reason for the medication, pain scale, interventions tried before the medication is given, the effectiveness of the mediation and the pain scale after the medication was given			

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	155764	A. BUILDING 00 B. WING	04/26/2012

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	for the above dates. The nurses' note, dated 4/2/12, indicated the resident was having "pain occasionally." The nurses' note, dated 4/6/12, indicated the resident was having no pain. The nurses' note, dated 4/15/12, indicated the resident was not having pain. During an interview on 4/19/12 at 3:14 p.m., RN #12 indicated the resident had not been assessed for the as necessary pain medication. RN #12 indicated she could not find anything to indicate the resident had been assessed for pain. This deficiency was cited on 2/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)			

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F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F0328	1. Resident J and N were assessed and no adverse findings were noted. 2.. An audit of residents' with nebulizer treatments was completed. No other residents were affected by this practice. 3.Licensed nurses were re-inserviced on assessment and documentation required with administration of a nebulizer treatments and pain medication. . Medication Pass observations and competencies were completed with nurses. 4. The DHS/designee will conduct audits of the MARs, nebulizer treatment documentation, daily orders, change of condition documentation, and Circumstance charting 5 times per weekly. Follow-up random medication pass observation will be scheduled with nurses. Observation will include all three shifts three times per week. DHS/designee will report findings monthly to QA&A for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for	05/16/2012

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	Based on observation, record review, and interview, the facility failed to assess residents prior to and after respiratory breathing treatments (nebulizer treatments) for 3 of 3 nebulizer treatments observed during 2 of 8 medications passes, for 2 residents in a supplemental sample of 11. (Residents J and N) Findings include: 1. During a medication pass on 4/18/12 at 12 p.m., RN #12 was observed administering an Albuterol nebulizer treatment to Resident J. RN #12 was not observed to check the resident's lungs sounds, respiration rate, oxygen blood saturation, or pulse prior to the administration of the nebulizer treatment. 2. During a medication pass on 4/20/12 at 6:02 a.m. through 6:52 a.m., LPN #1 was observed administering medications to resident N. LPN #1 administered an Albuterol nebulizer treatment to resident N. LPN #1 was not observed to check the resident's lungs sounds, respiration rate, blood oxygen saturation, or pulse prior to or after the administration of the nebulizer treatment.		any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved	

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	3. During a medication pass on 4/20/12 at 6:02 a.m. through 6:52 a.m., LPN #1 was observed administering medications to Resident J. LPN #1 administered an Albuterol nebulizer treatment to Resident J. LPN #1 was not observed to check the resident's lungs sounds, or respiration rate prior to the administration of the nebulizer treatment. LPN #1 was not observed to check the resident's lungs sounds, respiration rate, blood oxygen saturation, or pulse after the nebulizer treatment. During an interview on 4/20/12 at 7:45 a.m., LPN #1 indicated she should have checked the resident's blood oxygen saturations, respiratory rate, lung sounds, and pulse before and after a nebulizer treatment. A facility policy, dated 01/06, received from the Corporate Nurse Consultant as current, titled "Respiratory Inhalation Treatments Guidelines," indicated "...Prior to beginning the treatment a lung and heart rate assessment should be completed...Upon completion of the breathing treatment, reassess the lung sounds, pulse, respirations..." This deficiency was cited on 02/22/12. The facility failed to implement a			

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	systemic plan of correction to prevent recurrence. 3.1-47(a)(6)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review, and interview, the facility failed to monitor a resident's apical pulse when administering digoxin (a cardiac medication) during 1 of 8 medication passes for 1 resident in a supplemental sample of 11. (Resident J) Findings include: 1. During a medication pass on 4/20/12 at 6:02 a.m., LPN #1 was observed administering medications to Resident J. LPN #1 was observed administering	F0329	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident J. No adverse findings were noted. 2. All current residents medication records were reviewed and no other residents were affected by this practice. 3. Licensed nurses were re-inserviced on assessment and documentation required with administration of a of medication. Medication Pass observations and competencies were completed with nurses. 4. The DHS/designee will conduct	05/16/2012

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	digoxin 250 mcg (micrograms) tablet to Resident J. LPN #1 was not observed taking an apical pulse for 1 minute prior to the administration of the digoxin. During an interview on 4/20/12 at 7:45 a.m., LPN #1 indicated she should have checked the resident's apical pulse prior to the administration of the digoxin. During an interview on 4/20/12 at 7:50 a.m., the Corporate Nurse Consultant indicated an apical pulse should be taken with the administration of digoxin. The 2010 Nursing Spectrum Drug Book, indicated "digoxin...Patient monitoring Assess apical pulse regularly for 1 full minute..." This deficiency was cited on 02/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(a)(3)		audits of daily orders, MARs documentation, change of condition, and Circumstance charting 5 times per weekly. Follow-up random medication pass observation will be scheduled with nurses. Random medication pass observation will include all three shifts three times per week. The DHS will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved	

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F0333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a resident was free of a significant medication error, related to an omitted dose of Lanoxin (heart medication) for 1 of 7 residents reviewed for significant medication errors in a total sample of 7. (Resident #B) Findings include: Resident #B's closed record was reviewed on 04/19/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, short bowel syndrome and hypotension. The resident was admitted into the facility on 02/29/12 at 11:15 a.m. from the hospital. The resident was discharged to the hospital on 03/04/12 at 1:18 p.m. A physician consult, dated 03/06/12, indicated, "...At the time of her discharge...She had all of her medications spelled out, but apparently after she got there, they did not have her medications..." The transfer medication orders from the hospital, dated 02/29/12, included an order for Lanoxin 0.125 mg (milligrams)	F0333	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident B.. No adverse findings were noted. 2. All current residents medication records were reviewed and no other resident were affected by this practice. 3. Licensed nurses were re-inserviced on assessment and documentation required with administration, and holding of a medication. Medication Passes were completed with nurses. 4. The DHS/designee will conduct audits of daily orders, MARs documentation, change of condition, and Circumstance charting 5 times weekly. Follow-up random medication pass observation will be scheduled with nurses. The medication observation will include all three shifts three times per week. The DHS will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved	05/16/2012

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	daily. The medication administration record, dated 03/12, indicated by circled initials, the resident did not receive her Lanoxin on 03/01/12. The back of the MAR lacked documentation to indicate why the resident had not received the Lanoxin. During an interview on 04/20/12 at 6:35 a.m., the Regional Vice President indicated all the medications were given but the Lanoxin. She indicated the facility could not show where the Lanoxin had been given. Review of the 2010 Nursing Spectrum Drug Handbook, indicated for Lanoxin, "...take drug at same time every day. Instruct patient not to stop drug abruptly..." This deficiency was cited on 02/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-25(b)(9) 3.1-48(c)(2)			

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F0367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. Based on record review and interview, the facility failed to serve a therapeutic diet as ordered by a physician for 1 of 7 residents reviewed for diets in a total sample of 7. (Resident #B) Findings include: Resident #B's closed record was reviewed on 04/19/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, short bowel syndrome and hypotension. The resident was admitted into the facility on 02/29/12 at 11:15 a.m. from the hospital. The resident was discharged to the hospital on 03/04/12 at 1:18 p.m. A physician consult, dated 03/06/12, indicated, "...At the time of her discharge...She had all of her medications spelled out...they did not have her medications nor did she receive appropriate dietary changes for her short bowel syndrome..." The physician's transfer orders from the hospital, dated 02/29/12, indicated an order for a 1500 calorie soft diet, broken up into six meals a day.	F0367	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident J. No adverse findings were noted. 2. Diets of current residents were reviewed and no other resident were affected by this practice. 3. License nurses were re-inserviced on assuring that physician dietary orders are transcribed and communicated to dietary. 4. The Dietary Manager will audit all new admission for diet orders. Dietary Manager will conduct random audits of 5 charts per week to ensure diet orders match tray tickets. Dietary Manager will audit three meals per week to include breakfast, lunch and dinner, to ensure tray tickets are followed. Dietary Manager will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved	05/16/2012

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	The admission orders at the facility, dated 02/29/12, indicated for the resident to have thin fluids. The admission orders lacked documentation of a diet order. The Dietary Communication card, dated 02/29/12, received from the Dietary Manager, indicated the resident received a mechanical soft low concentrated sweet diet. The card lacked documentation to indicate the resident was to receive six small meals a day. The Nurses' Notes, dated 03/03/12 at 4 p.m., indicated, "Res (resident) c/o (complains of) not eating. Was given hot dog & shake & chips. Was served supper also..." During an interview with the admitting nurse on 04/20/12 at 8 a.m., LPN #10 indicated the physician had said to follow the hospital orders. During an interview on 04/20/12 at 9:30 a.m., LPN #11 (nurse who made out diet card), indicated a low concentrated sweets diet was the same as a 1500 calorie. She indicated she had not ordered the resident six small feedings. 3.1-21(b)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure	F0441	1. No adverse findings were noted related to this deficiency. 2.	05/16/2012

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	infection control practices were followed to prevent the spread of infection, related to hand washing and maintaining equipment to prevent the spread of infection, during 3 of 8 medication passes, for 6 residents in a supplemental sample of 11. (Residents J, N, #17, #18, #21, and #47) Findings include: 1. During a medication pass on 4/18/12 at 12 p.m., RN #12 was observed administering Albuterol nebulizer treatment to resident J. R#12 picked up the nebulizer mask from the resident's night stand. RN #12 indicated the nebulizer mask should be placed in a bag and she needed to get a bag for it. 2. During a medication pass on 4/20/12 at 6:02 a.m. through 6:52 a.m., LPN #1 was observed administering medications to Resident N. LPN #1 administered Albuterol nebulizer treatment to Resident N. The resident's nebulizer mask was not in a bag. 3. During a medication pass on 4/20/12 at 6:02 a.m. through 6:52 a.m., LPN #1 was observed administering medications to Resident J. LPN #1 administered Albuterol nebulizer treatment to resident J. The resident's nebulizer mask was not		An audit of physicians orders was completed to determine residents that require Pulse Ox, and nebulizer. Hand washing technique and cleaning of equipment between residents was reviewed with staff. No other residents were affected by this practice. 3. Licensed nurses were re-inserviced on hand washing techniques along with cleansing protocol related to use of Pulse Ox, and nebulizer equipment with use. Medication Pass observations and competencies that included infection control techniques were completed with nurses. 4. DHS/designee will conduct audits with random observation of medication pass by nurses to include use of Pulse Ox, administration of nebulizer treatments along with hand washing techniques. Observation will include all three shifts three times per week. DHS will report findings monthly for six months to QA&A. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved	

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	in a bag; it was laying on top of the oxygen concentrator. 4. During the medication pass on 4/20/12 at 6:02 a.m. through 6:52 a.m., LPN #1 was observed to wash her hands and leave Resident N's room. She then went to the nurses' station and picked up a glass and took a drink. LPN #1 then went to the medication cart to prepare medications for Resident J. She prepared the resident's medication of Albuterol and a nicotine patch and then entered Resident J's room. She applied the nicotine patch to the resident's upper right arm and removed the patch from the resident's back. The resident then complained of a rash. The nurse applied gloves and checked the resident for a rash. She then removed the gloves and washed her hands. LPN #1 then administered the Albuterol nebulizer treatment to the resident and then left the room. LPN #1 then went back to the medication cart and prepared the remaining medications for Resident J. LPN #1 then administered Resident J's medications and then left the room and entered Resident N's room to turn off the nebulizer treatment without washing her hands. 5. During an observation of medication administration pass on 04/20/12 at 5:55 a.m., LPN #13 prepared and administered			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #17's morning medication. LPN #13, then exited the room, and signed the Medication Administration Record (MAR). LPN #13 did not wash her hands or use alcohol gel. LPN #13 then prepared Resident #18's morning medications and administered the medications to the resident. LPN #13 then exited the resident's room and walked into Resident #21's room and checked his oxygen saturation with the oximeter. LPN #13 then exited resident #21's room and gave the oximeter to the Social Service Director. LPN #13 did not wash her hands or use alcohol gel between resident #17, #18, and #21. LPN #13 did not clean the oximeter after obtaining the oxygen saturation on resident #21. During an interview on 04/20/12 at 6:08 a.m., LPN #13 indicated she was to wash her hands after every three residents and sanitize her hands with alcohol gel in between residents. She indicated she did not wash her hands or use the alcohol gel. She indicated she did not clean the oximeter after she used it for Resident #21. She indicated she had just cleaned the oximeter prior to using it on the resident.			

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	155764	A. BUILDING 00 B. WING	04/26/2012

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	The Social Service Director then took the oximeter to LPN #14. LPN #14 then used the oximeter to check resident #47's oxygen level without cleaning the oximeter prior to using it. A facility policy, dated 10/04, received from the Regional Vice President as current, titled, "GUIDELINES FOR HANDWASHING", indicated, "...Health Care Workers shall wash hands at times such as:...Before/after having direct physical contact with residents...wash hands with soap and water after 4-5 uses of the waterless products..." A facility policy, dated 12/10, titled, "Pulse Ox (oximetry) Cleaning Guidelines", received as current from the Regional Vice President, indicated, "To prevent cross contamination when using a Pulse ox between residents...Gather disposable alcohol wipes or a bottle of alcohol and cotton balls to clean the Pulse ox...clean the pulse ox..." This deficiency was cited on 02/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(j) 3.1-18(l)			

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F0514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F0514	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident B.. Residents C, F, and G physician notification, admission care plans, documentation of, medication times, and physician orders were reviewed. No adverse effects were noted at this time 2. An audit of residents' medication record, physician notification, care plans and documentation of medication times were reviewed. No other residents were affected by this practice. 3. Licensed Nurses were re-educated on physician notification, admission care plans, documentation of medication times and obtaining physician order. 4. The DHS/designee will conduct audits of admission care plans, daily orders, MARs documentation, change of condition, and Circumstance charting 5 times	05/16/2012

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			weekly. DHS will report findings to QA&A for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved,	
	Based on record review and interview, the facility failed to ensure medical records where complete and accurate related to, physician notification, admission care plans, documentation of medication times, and physician's orders for 4 of 7 residents reviewed for medical records in a total sample of 7, (Residents #B, #C, #F, and #H) Findings include: 1. Resident #B's closed record was reviewed on 04/19/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, short bowel syndrome and hypotension. A) A Nurses' Note, dated 03/03/12 at 4 p.m., indicated, "...area around colostomy (sic) remains excoriated." A Nurses' Note, dated 03/04/12 at 11:30 (no a.m. or p.m. documented), indicated, "...excoriation around site remains..."			

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	The Nurses' Notes, dated 03/03/12 and 03/04/12, lacked documentation to indicate the facility notified the resident's physician about the excoriation around the resident's ileostomy. During an interview on 04/19/12 at 2:10 p.m., LPN #3 indicated she had attempted to notify the resident's physician, but the physician had not returned the call to the facility, so she notified the Medical Director and he said to just monitor the area. She indicated she did not write the notification in the resident's record. She indicated she did not put the area on a non-pressure skin sheet. B) Resident #B's admission nursing assessment, dated 02/29/12 at 11:15 a.m., indicated the resident had a colostomy for elimination. The elimination care plan on the admission assessment was left blank. During an interview with the admitting nurse on 04/20/12 at 8 a.m., LPN #10 indicated the ileostomy had not been marked on the admission sheet and there was no care plan for the ileostomy. An undated policy, titled, "Documentation Time Frames", received from the Regional Vice President on 04/20/12 at 10:10 a.m., indicated, "The following list of documentation time			

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	frames are the minimum requirements...Entry...Initial Assessment Initial Care Plan..." 2. Resident #C's record was reviewed on 04/19/12 at 10:45 a.m. The resident's diagnoses included, but were not limited to, dementia, arthritis, and gastroesophageal reflux disease (GERD). A physician's order, dated 04/11/12, indicated, tramadol (pain medication) 50 mg three times a day before meals. The MAR, dated 04/12, indicated the tramadol was scheduled to be given "before breakfast, before lunch, and before dinner." The MAR then indicated the resident received the tramadol before lunch and before dinner, with no times documented when the medication was given. During an interview on 04/19/12 at 10:55 a.m., RN #12 indicated if the morning medication is given late, she usually tries to give the lunch medication later. An undated policy, titled, "Medication Administration Times Procedural Guidelines", received from the Corporate Nurse Consultant on 04/20/12 at 11:25 a.m., indicated, "...The nurse administering the medications shall			

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	record the time the medication was administered along with his/her initials. a. The nurse shall note the time of the previous dose prior to administering the same medication to ensure it is not provided too close together..." 3. Resident F's record was reviewed on 4/18/12 at 12:10 p.m. Resident F's diagnoses included, but were not limited to, traumatic brain injury, seizures, and dysphagia. Nurse's notes, on 3/11/12 at 12:30 a.m., indicated "This writer entered resident room to find PEG (feeding tube) tube in his hand..." Nurse's notes, on 3/11/12 at 12:35 a.m., indicated "Foley cath (urinary catheter) inserted into ostomy (opening in stomach from feeding tube) to maintain patency. MD notified et (and) rec'd (received) orders to send to ER for tx (treatment)." The physician's orders lacked an order for the foley catheter to be inserted into the ostomy. During an interview with the Regional Vice President on 4/19/12 at 2:05 p.m., she indicated there was nothing in the chart pertaining to putting in a foley catheter when the resident pulled out the			

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	peg tube. During an interview with the RN Nurse Consultant on 4/19/12 at 2:30 p.m., she indicated she spoke with the nurse who was working that night. The nurse indicated she spoke with the doctor about it but she didn't write the order. 4. Resident H's record was reviewed on 4/18/12 at 1 p.m. Resident H's diagnoses included, but were not limited to, fractured left hip, hypertension, and arthritis. Resident H's admission nursing assessment, dated 3/30/12, indicated the resident had a surgical incision with 15 staples to her left hip The resident's record lacked documentation of a physician's order to remove the staples from the resident's left hip. A skilled nursing assessment, dated 4/6/12, indicated "4/4/12 3 p.m., Incision has 2 staples to well approximated incision..." There was a lack of documentation of the removal of the resident's staples or of the incision. During an interview 4/19/12 at 11:11 a.m., the Corporate Nurse Consultant			

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	indicated the physician had sent an order over to remove the staples, but they were not able to find the order. This deficiency was cited on 2/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-50(a)(1) 3.1-50(a)(2)			

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F9999	State finding: 3.1-14 PERSONNEL In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure facility staff received six hours of training (Employees #1, #17, #19, #20, #21, #22, #32, #33, #35, #37, #38, #39, #40, #41, #43, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, and #62) and three hours of dementia specific training (Employees #13, #16, #18, #24, #25, #26, #27, #28, #29, #30, #31, #34,	F9999	1. Employees noted in the CMS 2567 to lack Dementia Training were scheduled to receive the required training. No adverse effects were noted at this time.. 2. All employee records were reviewed and a list of employees who had not completed the required training completed. No other residents were affected by this practice. 3. All Employees noted to not have the required Dementia Training were scheduled for Dementia Training. 4. Human Resource Director / designee will conduct audits of Dementia Training completion weekly. HR will report findings monthly to QA&A for six months. 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved	05/16/2012

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	#36, #42, #44, and #61) annually for 48 of 144 employees who had been employed at the facility for more than 30 days (facility has an Alzheimer's/Dementia Special Care Unit). Findings include: Dementia specific training records were reviewed on 04/23/12 at 1 p.m. There was a lack of documentation to indicate 48 of 144 employees had received the initial six hours of dementia training (Employees #1, #17, #19, #20, #21, #22, #32, #33, #35, #37, #38, #39, #40, #41, #43, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, and #62) or the three hours annually (Employees #13, #16, #18, #24, #25, #26, #27, #28, #29, #30, #31, #34, #36, #42, #44, and #61) of dementia training required. During an interview on 04/23/12 at 1:30 p.m., the Regional Vice President indicated they have 30 days to complete the dementia training since the facility has a Special Care Unit. 3.1-14(u)			

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R0000	The following State Residential findings are cited in accordance with 410 IAC 16.2-5.	R0000	The submission of this plan of correction does not indicate an admission by Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus . This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities.(for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

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R0091	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to implement the written abuse policy related to a CNA not reporting suspected verbal abuse timely, which allowed the staff member the allegation was made against to continue to work and the residents of the facility were not protected from further potential abuse, for 1 of 3 residents reviewed for abuse allegations in a sample of 3. (Resident #131, CNA #49 and LPN #63) Findings include: Review of a State reportable for abuse on 04/19/12 at 10 a.m., indicated, an allegation of verbal abuse was made on 04/18/12 at 9:30 a.m. The "Incident Report Form", indicated, "...Incident Date: 04/18/12 (incident occurred on 04/17/12) Incident Time: 4:00 p.m. (Resident Name)(Resident #131)...Legacy Lane (Special Care Unit)...Brief	R0091	1. Due to the passage of time there is no opportunity to correct the circumstances related to resident. No adverse findings were noted. 2. Investigations related to allegation of abuse and suspected crimes were reviewed. No other residents were affected by this practice. Ongoing reports of known, suspected, or alleged abuse have been investigated and reported in accordance with guidelines. 3. Staff will be re-inserviced on the facility's policy for Abuse/Elder Justice Act and the procedures for reporting of any allegations of abuse to ensure protection of the residents. 4. The Executive Director will conduct audits of residents' allegations daily to assure that the facility implemented the policy concerning investigation and reported timely any allegation. The Executive Director will report findings to QA&A monthly for six months. 5. QA&A will monitor monthly for 6 months. QA&A will	05/16/2012

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	Description of Incident: Staff to resident allegation of abuse. Verbal abuse...Immediate Action Taken: Nurse (Name) suspended pending investigation. MD notified no new orders. Family notified. Preventive measures taken: Investigation continues..." A hand written statement, dated 04/18/12 (the day after the incident occurred), signed by CNA #49, indicated, "On 4/17/12 I (CNA Name) witness verbal abuse from a nurse on legacy. The Nurse (Name) yelled at (Resident Name) (Resident #131) at lagacy (sic) for hitting her in the chest. The nurse stated to (Resident Name) why did you hit me in the chest. How would you like it if I hit you in your chest. She then left the unit for about 20 min. (minutes). When she returned she stated that she is never coming back over to the unit to work again." A hand written statement, dated 04/18/12, signed by LPN #63, indicated, "...assisting to move (Resident Name) to a new wheelchair...During the move (Resident Name) (Resident #131) became angry and punched me in the chest. When he went to hit me again I grabed (sic)/stopped his arm put it down and told him that's (sic) not nice (Resident Name) we dont (sic) punch people. I finished transferring and		monitor for any trends and make recommendations to Plan of Correction and will expand audits until 100% compliance is achieved	

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	getting him situated in his new chair and told the CNA I needed to step away for a moment, I did then came (sic) back to finish passing meds (medications) to other residents Somewhere during conversation I said something within the relm (sic) I was so done with this day and just ready to go home..." During an interview on 04/19/12 at 10:20 a.m., the Legacy Unit Manager indicated CNA #49 reported the incident to her on 04/18/12 at 4 p.m. She indicated the actual incident had happened the evening before. She indicated the CNA should have reported it immediately. She indicated the facility policy states the nurse should have been sent home so the residents would be protected from possible further abuse. She indicated the facility policy was not followed. She indicated the CNA first said the nurse just yelled at the resident. During an interview on 04/19/12 at 10:25 a.m., the Administrator indicated the CNA didn't think much of the yelling, then thought about it and then reported it. He indicated the date was incorrect on the reportable to the state and the incident occurred on 04/17/12. A facility policy, titled, "Abuse and Neglect Procedural Guidelines", dated			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	11/2010, and received from the Minimum Data Set Nurse as current, indicated, "...Staff is required to report concerns, incidents and grievances immediately to your manager and/or Executive Director and Director of Health Services...Any person with knowledge or suspicion of suspected violations shall report immediately...immediately provide for the safety of the resident...This may include...Suspend suspected employee(s) pending outcome of investigation..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	04/26/2012

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R0241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.	R0241	1. Resident's 85 and 105 medication records were reviewed. Physicians were notified and orders clarified. No adverse findings were noted. 2. An audit of residents' medication orders and evaluation for self administration of medications were reviewed and updated. No other residents were affected by this practice. 3. Licensed nurses were re-educated on documentation and assessment with administration of medication, along with the required documentation of a self administration evaluation prior to allowing a resident to administer their own medication. Medications Passes were completed with nurses. 4. The Director of Nursing/designee will conduct audits of residents' self administer evaluation on admission and with service plan update. Random Medication Pass Observations will be continue monthly and audit results reviewed with individual nurses 5. QA&A will monitor monthly for 6 months. QA&A will monitor for any trends and make	05/16/2012

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			recommendations to Plan of Correction and will expand audits until 100% compliance is achieved.	

Based on observation, record review, and interview, the facility failed to administer medications as ordered by a resident's physician, related to not administering a medication at the right time and a nurse allowing a resident to self-administer a nebulizer treatment, when the resident had not been assessed for self administration of medications, for 2 of 4 medication administration passes observed, affecting 2 residents in a supplemental sample of 2. (Residents #85 and #105, LPN # 62)

Findings include:

1. During a medication administration observation on 4/23/12 at 10:45 a.m. with LPN #62, after checking the medication on the MAR (Medication Administration Record), she took a nitroglycerin patch (heart medication) out of the box and wrote the date on it. During an interview at the time of the observation, LPN #62 indicated the patch was late. She indicated the patch was supposed to be put on at 9 a.m. She went into Resident #105's room and checked the resident's chest and back and found the resident had a nitroglycerin patch on his right chest area that was dated 4/22/12. During an

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	interview at the time of the observation, LPN #62 indicated "It should have been taken off at 9 p.m. on 4/22/12." LPN #62 then applied the new patch to the back of the resident's right shoulder. During an interview on 4/23/12 at 11 a.m., LPN #62 indicated she was going to call the physician and let him know the nitroglycerin patch had not been removed the night before and was late today. Resident #105's record was reviewed on 4/23/12 at 11:05 a.m. Resident #105's diagnoses included, but was not limited to, hypertension. A clarification order, dated 3/26/12, indicated "Nitroglycerin 0.2 mg (milligrams)/hr (hour) apply daily for HTN (hypertension) (topical) on @ 9 a.m. off @ 9 p.m..." 2. During a medication administration observation on 4/23/12 at 1:15 p.m. with LPN #62, she took Albuterol (bronchodilator) .083% 1 unit and took it into Resident #85's room. LPN #62 then poured the contents of 1 unit in the nebulizer mask. Resident #85 then propelled herself in her wheelchair over to the nebulizer machine, put on the mask, and turned on the machine. LPN #62 left the resident's room.			

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	Resident #85's record was reviewed on 4/23/12 at 1:30 p.m. Resident #85's diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and atrial fibrillation (heart arrhythmia). A physician order, dated 4/5/12, indicated Albuterol .083% one per nebulizer treatment every 8 hours for COPD. The resident's record lacked a self administration of medications assessment or an order for self administration. The resident's service plan indicated "...Medication and Treatments...Assist with administration..." During an interview on 4/23/12 at 1:35 p.m., LPN #21 indicated the nurses are supposed to stay with the residents unless they have an order to self administer. She indicated there was not anything in the resident's chart that says she can do it by herself. During an interview on 4/23/12 at 1:55 p.m., LPN #62 indicated she did not stay with the resident during the nebulizer treatment. She indicated the resident knows when to shut it off. She indicated there was not as assessment for the resident to self administer medications			

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	and it was not on the service plan. A facility policy, dated 02/10, titled, "Medication Administration-General Guidelines", received from the Medical Records Nurse as current, indicated, "...Medications are administered in accordance with written orders of the attending physician...Medications are administered within 60 minutes of scheduled time...Residents are allowed to self-administer medications when specifically authorized by the attending physician..." This state residential finding was cited on 2/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence.			